trained for this particular task. The tabulation and interpretation of statistics like the cure of the sick, is a distinct art and this kind of work can be best done only by those who are trained in the art. This means that the statistician and the physician must work in the closest coöperation. Each has his part in the important work of collecting, tabulating, and analyzing the results of medical and hospital experience; the doctor to keep the records and the statistician to tabulate and analyze them. Nursing is likewise served by the application of statistical results to the facts of sickness in the community. The nurse also has her part to perform in the keeping of sickness records. Schools for the training of nurses, therefore, as well as those for the training of physicians, should impart to their students a proper appreciation of the importance of the keeping of hospital and medical records.

RELATION OF CLINICAL TO SOCIAL RECORDS[1]

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It is not without hesitation that I, not an authority on social service work, speak before such an assembly of experts on the subject of social service records. It is because social service departments have become so important in our civic hospitals and because social service records, together with the medical records, do now, and are going to still further, play so vital a part in the problems of hospital construction, as well as organization, that I take this opportunity to do so.

There are so many parallel and striking analogies between social and medical work that I believe the method used for recording medical work could be applied to social records and that it would lead to simplification and to far-reaching results in the future.

Social work, like medical, may be divided into the science and the art. A knowledge of the sciences of anatomy, physiology, pathology, are essentials to the surgeon dealing with a fractured bone. Deviation from nature's laws embodied in these sciences meets with disaster. The art of surgery, however, in treating the fracture, affords many methods, the rationale of which complies with these laws. A wooden splint, for example, may serve the purpose and satisfy these natural laws quite as well as one made from plaster of Paris. A knowledge of the science of ethics, economics, or tenement house construction, may be essential to the social worker dealing with a fractured life. The art of dealing with it, in compliance with these

[1] Read at the twentieth annual convention of the American Nurses' Association, May 1, 1917.

scientific laws and principles, may call for methods as many as the sands of the sea. The science and art of social service will be and has been developed, as the science and art of medicine will be and has been, by the accurately-recorded observations of trained observers.

Organized social service work is a development of recent years; not so medicine. It would be the grossest of crimes against intelligence for the recording of observations of social work not to profit by the mistakes made in the recording of medical observations. It is the purpose of this paper to indicate some of the mistakes that have been made in the past, and that, I regret to state, are still being made in a vast number of places, in the recording of medical observations; to indicate what steps are being taken to avoid them in the future; and to present for your consideration those steps that must be taken in the recording of social observations to avoid those errors.

You are all familiar with the old-time customary methods of taking records of hospital patients. On admission to a hospital, the patient's name with identification data was taken and included on the patient's chart during his stay in the hospital. On discharge, a diagnosis of the patient was written on the chart, according to the notions of the house officer, irrespective of the fact that different house officers might call the same disease by different names. The patient's chart was ultimately bound in a volume containing the case records for that year, and a discharge card was inserted in a name file as the sole means for future reference. Periodically an annual report was written by the house officers for the superintendent to present to the managers, indicating the diseases, operations, and results tabulated under the time-worn and misleading headings of "Cured," "Improved," "Unimproved," and "Died." The trustees looked with evident satisfaction at the number of cases reported as "Cured," which generally included a number of cases of cancer that had undergone an operation. It was gratifying to the friends of the hospital to see that if not cured, so many patients had "Improved." That patients should have been discharged "Unimproved" was undoubtedly a cause for regret not unmingled, however, with satisfaction that this list was generally the smallest. The list of those who died, the only accurate list, carried with it a sense of the inevitable, but an analysis of the causes of death if made, was practically never scrutinized. No accurate, statistical knowledge was available to those who were responsible for the running of the hospital. Histories were not grouped according to the various diseases, because it was stated that a terminology of diseases could not be written that would be practical. Histories were bound in large volumes, so that when the patient returned for the same or

another cause, a new history had to be abstracted or written. When histories were required for study, by a doctor of a certain type of disease, it was impossible for him to find them unless he had kept a private diagnosis file of those relatively few cases that had come under his observation. In a dispensary or out-patient department, where a vastly greater number of patients was being treated, equally important as those within the hospital, records were even more meagre and similarly unclassified, or else no records whatever were kept beyond entering the patient's name in a book. Absolutely no idea of the late results could be obtained from any of these records. From the standpoint of the science and art of medicine, these histories, after the patient was lost sight of, might better have been burned than take up the space that they occupied on the shelves. Furthermore, the practically impossible task of subsequent classification of these records for medical statistics would have been of no avail, because the data that they contained of similar diseases, varied so greatly, according to the different men who made the records, that, were an attempt made to put them together for further study the data would have been so incomplete that it would have been impossible to draw conclusions. Only last year I found that there were nearly a million records, from only three institutions in New York, piled away, absolutely worthless from a medical standpoint because of this lack of classification. It is not exaggeration at all to say that throughout the country several millions of records have been made during the past twenty-five years that are of absolutely no use from a medical or surgical standpoint.

Because the analogies between social and medical work are so strong, I shall trace the fundamental principles governing the changes that have been and are being made in the making and filing of medical records.

In order to find for subsequent study all the histories of cases suffering from a certain disease, it is necessary that all such histories be marked by one term that shall be the only officially recognized term to be used in indicating and filing that particular disease. I would emphasize the words "to find for subsequent study." The diagnosis file, and the terms used for diagnosis, though they may indicate the relative frequency or absolute number of grouped cases in that institution, is not meant for analysis nor description of the disease in itself. These terms are merely to locate groups of cases desirable for study and should be chosen with that in mind. In order that different terms should not be used for the same disease, a terminology of disease, under which all diseased conditions could be grouped, had to be compiled. This book that I hold in my hand, written by Doctors Adrian Lambert and Wal-

ton Martin of New York, is such a terminology and is based, as far as possible, on the causes of disease. It is freely admitted to be imperfect by its authors, because since its edition, many terms have been altered. A new edition is soon to appear; nevertheless, it is rather generally admitted now to be the best terminology of disease for practical use that has been published. No history is allowed to be filed unless the terms of the diagnosis correspond precisely to one of the terms in this book. If, as happens occasionally, an additional term is desired by any one, it can only be added after it has been submitted to that person in whom the authority is vested to make changes in the book and has been officially added by him to the terms already listed. Should the patient be suffering from more than one disease, no attempt is made to differentiate a main condition and complication, the different diseases are spoken of as accompanying one another. The histories are not bound but are used again whenever the patient returns.

Now this grouping of cases is essential, but does it go far enough? Put yourself for a moment in the position of the physician, shall we call him an "intensive" worker in medicine, studying a certain disease and anxious to tabulate the statistics of the many details relating to that disease? In the record room he asks for the records of all the cases belonging to a certain type of disease. The record clerk readily turns to the card corresponding to that disease and soon a large pile of these individual case histories confronts the physician. To examine the detailed information in all these histories is a task likely to dismay all but the most undaunted worker. Add to this, however, that the physician is most anxious to secure statistical data with perhaps ten detailed points. Can he get them? The chances are overwhelmingly that he cannot. The writer of a record five years ago may have included ten of these points; the writer of the record two years ago may have omitted them all; and the writers of the intervening years may or may not have included them. Thus we see that though these case histories are grouped according to disease, the statistical details are not there. The diagnosis file, therefore, must be supplemented still further to make the records of real use. How then are these statistical details to be secured? What is the obvious thing for the intensive medical worker to do? He at once makes a list of all of the details that he considers important from the standpoint of the science and art of the disease in question. In future, whenever a case is considered to be suffering from the disease in question, this analytical list or sheet is placed on the chart so that all the desired details can be recorded in all the cases. Subsequently, when

the worker collects his group of cases the facts that he desires are there. Better yet, however, is the method by which symbols are used at the bedside, qualifying the details on the analysis sheets, so that when the history arrives in the record room these symbols can be transcribed by the record clerk to large synthetic tabulating sheets that correspond to the details of the analysis sheet for that particular disease. In this way the correct statistics about any particular disease being intensively studied are always available. How often these statistics shall be made up is a matter for common or individual discretion. Let me briefly demonstrate the ways in which this recording is done:

Demonstration of forms: Admission card and number, face sheet, general history, analysis sheet, operation sheet, discharge diagnosis and operation performed, terminology of disease, follow-up sheet, diagnosis file, operation file, follow-up file, subsequent use of histories in out-patient department including follow-up, continuation of records on re-admission, synthetic statistical sheet.

I think a moment's thought is sufficient to convince anyone that, in instituting a system of record-keeping, one should select the system that is as complete, yet as elastic, as possible, so that in ten or more years' time an institution will not have to regret that its system was wrong; that it was incomplete; and that it was so inelastic as to be incapable of admitting further additions. In other words, the plan should be to establish an ideal system at the start. Furthermore, if all the factors of an ideal system cannot be complied with in different institutions, such modifications should be made that in the natural order of development, failures to comply with an ideal system may be obviated as time goes on with the least possible disturbance to the system.

The so-called unit history system is an ideal toward which every hospital should strive. A unit history system implies that all the records of a patient admitted to any department of that hospital at any time shall be kept in one place. It refers to the out-patient department, the histories of ward patients, the social service histories, the follow-up records, special examination, even the microscopical sections and museum specimens, or communications about patients, and even the records of the executive department of the hospital. This brings to the foreground a factor in hospital construction so fundamental that I believe in the future building of hospitals it will be regarded as an axiom. The record room for the whole hospital will have to be so situated as to be immediately available for the executive offices, the admission and discharge thoroughfares, the out-patient department,

the social service department, the follow-up department, the pathological museum and even for, perhaps, two or three other departments that may in the future be found to play an essential part in the dealing with patients, either before or after they have been in the wards. It is not essential that the record room be near the wards. When a patient is in the ward, the history accompanies the patient for a considerable period of time. By so doing, all the records of a patient would be complete and in one place. The staff of clerks used for doing this kind of filing work in the different departments could be reduced. The use of separate name files for each department could be merged into one and the clerks, workers, and the energies of each department could be devoted to the analysis and the synthesis of the work done by each department which is an end most to be desired. That such a scheme of organization, though it is in process of development in several institutions, does not exist, is, as far as I know, true, but if there is one thing we feel sure of, it is that this plan is bound to come.

If the unit history system is the ideal toward which we should aim, one thing stands out preëminently for social service workers to accomplish. Social service cases must be grouped for further study just as much as the medical cases are. To group medical cases for further study, a terminology of disease had to be written. To group social service conditions for further study, a terminology of social conditions will have to be written. It was stated over and over again by medical experts in high standing that an accurate and complete terminology of disease could not be compiled. It was stated that the causes of many diseases were not known. It was stated that the unknown causes of many diseases were being found out, with the result that the terms used in describing such a disease had to be changed. Many other objections were raised. Nevertheless, many terminologies have been written and as I stated before, the terminology that I present to you, though it has been changed and added to since its first edition, is being used with success, and is being adopted all over the country by various institutions. It is not enough to state that a terminology of social conditions cannot be written. Such a statement may be an opinion but it is not a fact. It can be written. It should be written. It may take months and years to do it, as the terminology of disease did, and it may require the best minds and the most experienced workers in social conditions to do it. Bear in mind that these terms should be strictly social terms and not medical. The medical terminology has been written already for you. If the medical terms are not already on the record, though most of them will be, if your

work be in connection with a hospital, the terms are at your disposal and can be added by you as indicated. It would therefore probably be unwise for a social terminology to include the terms used in a medical terminology.

The filing of these social diagnoses should be done in a common file with the medical diagnoses, so that any combination of medical and social diagnoses can be located and assembled for subsequent study at a moment's notice.

Still further, in a parallel way to the intensive study of medical subjects, the intensive study of social problems can be carried on by the analytical sheets and synthetic charts. The work done can be filed in a precisely similar manner to the operative treatment file already in use. The slight service and the intensive work can both be carried on under this one system.

The purpose of this paper has been to present for your consideration the analogies between medical and social records; to urge that the mistakes made in the keeping of medical records be avoided; to emphasize the importance of aiming at an ideal system, the most immediate, absolute requisite for which is the preliminary compiling of a terminology of social conditions.

THE VALUE OF THE INDUSTRIAL NURSE'S RECORDS TO HERSELF AND TO HER EMPLOYER[1]

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A rather wide inquiry into the question of the industrial nurse's records and the uses made of them reveals a lack of uniformity of method and purpose, which would seem to explain the blindness of many nurses and employers as to their value. The methods in vogue range all the way from absolutely no record at all (not even a day book) to a full family, work and disability history of each employee. In the replies to our inquiries, there was a significant relation between the kind of record kept by the nurse and the apparent value of that record in the eyes of her employer. In other words, a letter was sent at the same time to the nurse and to the company employing her. In each case where the records were fairly complete and where the nurse had sufficient help to properly tabulate and interpret them, that particular employer spoke with conviction of their definite usefulness.

[1] Read at the twentieth annual convention of the American Nurses' Association, May 1, 1917.